〔原著〕

訪問看護師が高齢者の「呼吸停止確認」を担う場合における注意点

齋 藤 美 華[1)]・村 崎 志 保[2)]・佐 藤 千 穂[1)]・川 原 礼 子[3)]

Important points when a visiting nurse confirms respiratory arrest of an elderly person

Mika Saito[1)], Shiho Murasaki[2)], Chiho Sato[1)], Reiko Kawahara[3)]

Abstract

This study examined responses from 122 visiting nurses to a questionnaire related to aspects of respiratory arrest confirmation for elderly people near death. Of those 122 nurses, 53 had confirmed respiratory arrest before; 69 had not. More than half of the respondents had done respiratory arrest confirmation.

Among Certified Nurses and Certified Nurse Specialists, respondents who think "it is agreeable to do" were significantly more numerous among those who "had confirmed respiratory arrest." In the "had not confirmed respiratory arrest" group, significantly many respondents chose "A nurse should be able to confirm respiratory arrest if conditions are met." Moreover, significantly more Nurse Certificate and Certified Nurse Specialist respondents reported that they could say neither, irrespective of whether they had done confirmation of respiratory arrest, or not. Results suggest that holding certification as a Certified Nurse or Certified Nurse Specialist is related to approval or rejection of a nurse's ability for "confirmation of respiratory arrest."

Key words：end-of-life care, confirmation of respiratory arrest, visiting nurse, elderly people, Certified Nurse, Certified Nurse Specialist

Ⅰ. Introduction

In Japan, which has entered a super-aged society and which has reached an era of rapid aging, interest in end-of-life care at home has been increasing. Confirmation of death by a nurse has become a particularly important issue.

Today, upon a person's death, the doctor who prepares a death certificate based on the Doctor Law must work with an attitude of 24-hour availability because doctors are prohibited from delivering medical certificates without seeing the deceased personally. Moreover, by Article 20 of the Doctor's Law, they are

1）山形県立保健医療大学　保健医療学部看護学科
〒990-2212　山形市上柳 260
Department of Nursing,
Yamagata Prefectural University of Health Sciences
260 Kamiyanagi, Yamagata-shi, Yamagata, 990-2212, Japan

2）宮城大学　看護学群
〒981-3298　宮城県黒川郡大和町学苑 1-1
School of Nursing, Miyagi University
1-1 Gakuen, Taiwa-cho, Kurokawa-gun, Miyagi,
981-3298, Japan

3）東北大学　名誉教授
〒980-8575　仙台市青葉区星陵町 2-1
Professor Emeritus, Tohoku University
2-1 Seiryo-machi, Aoba-ku, Sendai, 980-8575, Japan

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obliged to examine the deceased person themselves even when delivering a death certificate. Nevertheless, given the difficulties of end-of-life care systems, it might take some time for a doctor to visit a home or elderly facility, even excluding cases of rapid state change and death by attempted suicide, etc., deriving from the course of the disease. Regarding deaths that are expected, situations have been reported in which death confirmation is done by a nurse [1) 2)], thereby threatening smooth end-of-life care. The current state of end-of-life care at elderly care facilities has clarified that nurses have confirmed cardiopulmonary arrest and respiratory arrest, explained it to families, and confirmed substantial death as entering into *Angel Care*, care for post-mortem treatment, before a doctor's arrival [3)].

Confirmation of death by a nurse is an issue related to the review of regulation in end-of-life care at home by the Ministry of Health, Labor and Welfare in 2015. On September 28, 2016, the Cabinet Office announced[4)] deregulation for regulatory reform for end-of-life care at home. The agreement contents are related to advance correspondence at the terminal term, with sufficient cooperation between the doctor and the nurse, and permission of confirmation of death given by the nurse when there is consent of the patient and the family. Furthermore, on September 12, 2017, the Ministry of Health[5)], Labor and Welfare notified prefectural governors about the handling of death diagnosis using information and communications technologies (ICT). Realization of nurses' death confirmation at home is unavoidable. It is important to clarify difficulties of the current situation of attention points by visiting nurses at home sites to support the calm death of elderly people, which is an important task related to elderly nursing and which can ensure a death that fulfills life[6)].

A study of attention points when nurses conduct confirmation of death revealed the importance of daily role sharing with doctors, trust relationships with family members, grasping an understanding and acceptance of family, and confirming death in hospice and palliative care units[7)]. At facilities for elderly people, it has been revealed that teams including families commonly recognize and cooperate in the reconfirmation of vital signs[3)]. However, points of caution of confirming death by a visiting nurse who is at a home site remain unclear.

Perspectives and death confirmation by visiting nurses can be shown to guarantee the quality of end-of-life care nursing for elderly people and their families. Nursing education related to death confirmation by nurses at home is being realized. This study was conducted to elucidate important points to be observed when a visiting nurse is responsible for confirming respiratory arrest in elderly people near death, specifically examining visiting nurses.

Terms related to death confirmation and death diagnosis are defined only ambiguously, but include "confirmation of respiratory arrest," "confirmation of cardiopulmonary arrest," "confirmation of death," "diagnosis of death," and "delivery of a medical certificate." Therefore, in this study, "respiratory arrest confirmation," one of the three vital signs was defined and used as encompassing substantive death confirmation. A nurse might explain to the family that breathing has stopped and might carry out Angel Care before the doctor arrives. Currently a nurse is not legally permitted to confirm death, which is an inappropriate policy considering the legal and practical difficulties outlined above.

Ⅱ. Methods

1. Subjects and Methods

As reported in the October 1, 2012 Survey of Institutions and Establishments for Long-term Care, Ministry of Health, Labor and Welfare[8)], 6590 visiting nursing station facilities exist nationwide. Of those, 150 visiting nurse stations are registered on the website of Association for home-visit nursing care[8)]. Randomly, 150 persons were chosen by extraction of Certified Nurses among visiting nurses registered with the Japanese Nurse Association. A questionnaire survey was administered by mailing. For selection of respondents, Certified Nurses and visiting nurses were included on the possibility that medical exercise related to end-of-life care was conducted because of

high professional consciousness. For Certified Nurses among visiting nurses, the questionnaire was sent to employees by mail. For visiting nursing stations, it was mailed to the responsible person among the nurses, asking a visiting nurse interested in end-of-life care to fill in the form anonymously and to mail it back to researchers. The survey period was January- February, 2015. For this paper, the terms “nurse,” “visiting nurse,” and “certified nurse in visiting nurse” are unified as “nurse.”

2. Investigation

1) Basic attributes of respondents

Age, gender, acquisition license, clinical nursing history, visiting nursing history, nursing education history were examined.

2) Whether or not respiratory arrest confirmation is implemented: approval or rejection

We assessed whether or not nurses routinely conduct respiratory arrest confirmation for elderly people near death in visiting nursing scenes. In addition, regarding implementation of respiratory arrest confirmation, we asked respondents to choose either [1] I should not, [2] I agree, or [3] I cannot say either.

3) Important points when a visiting nurse is responsible for confirmation of respiratory arrest in elderly people near death

For those who answered that they are doing respiratory arrest confirmation for elderly people near death, we asked for free responses on points of caution in carrying out respiratory arrest confirmation.

3. Analytical method

Data for basic attributes of respondents were obtained from simple tabulation. A Fisher’s exact test was conducted of characteristics based on the presence or absence of Certified Nurse and Certified Nurse Specialist qualifications and the relations between nurses’ implementation of respiratory arrest confirmation and approval or disapproval. Statistical testing was done using software (SPSS Statistics 22; IBM Corp.). Results for which probability was less than 0.05 were inferred as significant.

Free text responses were given on important points when a visiting nurse is responsible for confirmation of respiratory. Qualitative content analyses of the responses were conducted. Specifically, we carefully read the descriptions of free responses, extracted descriptions of minimum units representing reasons and ideas, encoded them, and categorized them based on the similarity of meaning contents. Three educators and researchers specializing in gerontological nursing participated in securing the stringency and veracity of this study. The categories are denoted with [ ]. Codes are denoted with < > .

4. Ethical considerations

We informed the Japanese Nurse Association by e-mail, asking in advance for their explanation and cooperation in the purposes of the research. Additionally, we sent a request document, a letter of intent and a questionnaire to persons responsible for visiting nursing stations. We asked for their cooperation with an enclosed explanatory document describing ethical considerations to the respondents, which also explained that returning the questionnaire signaled their agreement to participate in this study. This study was approved by the ethics committee of Tohoku University Graduate School of Medicine.

Ⅲ. Result

1. Outline of Target

Of the 300 visiting nurses surveyed, 124 returned the questionnaire, among whom 122 described in the contents on “respiratory arrest confirmation” had experienced “respiratory arrest confirmation.” There were 69 people in all in the group. There were 25 people (20.5%) who answered “I do not think it should,” one (0.8%) reported that “I agree” 43 people (32.8%), “Neither one” 25 people (20.5%) Met. There were 53 people (43.4%) in all for the group not “checking respiratory depletion,” 3 people (2.5%) who responded “I should do” and “thinking that it is okay to implement if conditions are met.” There were 33 people (27.0%), 5 people (opposite) 5 people (4.1%), and 12 people (9.8%) “Neither one”. For this study, the 69 respondents who responded that they had

Table 1　Basic Attributes of the Target

N=69

			n (%)
attribute	Age [1]		48.7±6.7 [32-70]
	Age distribution	30--39 years old	7 (10.1)
		40--49 years old	26 (37.7)
		50--59 years old	34 (49.3)
		60--69 years old	1 (1.4)
		70 years and over	1 (1.4)
	sex	Male	0 (0.0)
		Female	69 (100.0)
	Acquired license (Multiple answers)	Public health nurse	3 (4.3)
		Midwife	2 (2.9)
		Nurse	66 (95.7)
		Quasi-nurse	6 (8.7)
		Certified nurse	28 (40.6)
		(Visiting nursing)	27 (39.1)
		(Palliative care)	1 (1.4)
		Certified Nurse Specialist	1 (1.4)
		(Dementia care)	1 (1.4)
	Clinical nursing history [2]	17 years 2 months	[2 years 9 months – 32 years 0 months]
	Visiting nursing history [2]	10 years 3 months	[0 year 2 months – 20 years 0 month]
	Nursing education history [2]	Vocational school graduate	61 (88.4)
		College graduate	6 (8.7)
		University degree	1 (1.4)
		Graduate school (master) degree graduat	2 (2.9)

1) The numerical value shall be an average value ± standard deviation [minimum value - maximum value]
2) The numerical value shall be the average value [minimum value - maximum value]

Table 2　Characteristics with and without qualification of Certified Nurse/ Certified Nurse Specialist qualification

N=69

		Certified Nurse, Certified Nurse Specialist Qualified (n=29)		Certified Nurse, Certified Nurse Specialist No qualification (n=40)			
		Mean ± SD	Number of people (%)	Mean ± SD	Number of people (%)	p value	
Age[a]		48.0±5.8		49.2±7.3		0.463	ns
Nursing history (Month)[a]		192.4±100.3		215.5±98.0		0.348	ns
Visiting nursing history (Month)[a]		150.2±54.1		105.3±68.2		0.005	**
Nursing education history [b]							
Vocational school graduate	no		4 (13.8)		4 (10.0)	0.712	ns
	yes		25 (86.2)		36 (90.0)		
College graduate	no		26 (89.7)		37 (92.5)	0.690	ns
	yes		3 (10.3)		3 (7.5)		
University degree	no		28 (96.6)		40 (100.0)	0.420	ns
	yes		1 (3.4)		0 (0.0)		
Graduate school (master) degree graduate	no		28 (96.6)		39 (97.5)	1.000	ns
	yes		1 (3.4)		1 (2.5)		

**p<0.01 ns:not significant
a) t test
b) Fisher's exact test

Table 3　Association with approval / disapproval of 'respiratory halt confirmation' in relation to existence of qualification of professional nurse

N=69

approval / disapproval of 'respiratory halt confirmation'	n (%)
[1] I think that should not be done	1(1.4)
[2] I agree	40(58.0)
[3] Neither Agree Nor Disagree	25(36.2)
No response	3(4.3)

Certified Nurse, Certified Nurse Specialist Qualified (n=29)	n (%)	Certified Nurse, Certified Nurse Specialist No qualification (n=40)	n (%)	p value	
[1] I think that should not be done	0 (0.0)	[1] I think that should not be done	1 (2.5)	1.000	ns
[2] I agree	23 (79.3)	[2] I agree	17 (42.5)	0.003	**
[3] Neither Agree Nor Disagree	5 (17.2)	[3] Neither Agree Nor Disagree	20 (50.0)	0.006	**
No response	1 (3.4)	No response	2 (5.0)		

**p<0.01 ns: not significant
Fisher's exact test

experienced “respiratory arrest confirmation” by a visiting nurse were targeted.

Table 1 presents basic attributes of those 69 respondents. Their mean age was 48.7 ± 6.7 years old (range 32-70 years). All were women. Regarding acquired licenses, 66 nurses and 6 nurse were included in this study. Among them, 28 were qualified as certified nurses (27 visiting nurses, 1 palliative care) ; 1 was qualified as a specialized nurse (dementia care). The average clinical nursing care history was 17 years and 2 months. The average visiting nursing history was 10 years and 3 months. Furthermore, regarding characteristics based on the qualifications of accredited and professional nurses, 150.2 ± 54.1 (months) was found as average period of visiting nursing history persons qualified as an accredited / specialized nurse, although those without qualification had an average of 105.3 ± 68.2 (months), person with qualification / specialized nurse qualification was significantly longer than those without qualification (Table 2).

2. Relationship with certification / absence of qualification of specialized nurse in approval / disapproval of “respiratory arrest confirmation” by nurse (Table 3)

Regarding the approval or disapproval of “respiratory arrest confirmation” by nurses, for people qualified as accredited and professional nurses, no respondent chose “I do not think it should,” but 2) was chosen by 23 people (79.3%). Also, 3) “neither one” was chosen by (17.2%), but answer 4) earned one response (3.4%). Additionally, for those who are not qualified as accredited and professional nurses, 20 people (50.0%), No answers to two (5.0%), No answer (1%), One person (2.5%), 2) “I agree” 17 people (42.5%).

Regarding the relation between certified and specialized nurse qualified persons and those without qualification, those who are qualified as certified / specialized nurse responding that they are “in favor” of implementation of “confirmation of respiratory arrest” were significantly more numerous ($p < 0.002$). Significantly fewer people responded that they “cannot say either” ($p < 0.005$).

3. Important points for cases in which the nurse is responsible for “suction stop confirmation” in “expected death” of elderly people (Table 4)

For nursing at the “expected death” of elderly people regarding notes on “respiratory stop confirmation,” 30 respondents were qualified as certified / specialist nurses, but 34 respondents were without certification / specialist nurse qualification. As categories, the following were extracted for both: [I commonly recognize and deepen collaboration within the attendance team including family members], [I respond while considering the feelings and circumstances of the family], [I do Angel Care with respect to users and family feelings], and [I support the user and the family so that they can visit as desired] were extracted for both.

For people qualified as accredited and specialist nurses [I consider the family’s death considering the arrival time of the doctor] and [I correctly confirm the signs of death] were extracted. As category of nurses without certification / specialist nursing qualification [I wait until the arrival of the doctor while supporting the family without doing diagnosis or treatment] and [I confirm signs of death] were extracted.

Ⅳ. Discussion

1. Important points for respondents and recognition of confirmation of respiratory arrest

Results show that 28 out of 69 respondents were qualified as certified and specialized nurses. Many more certified / specialized nurses think that they are “agreeable” to “implementation of confirmation of respiration” than those who have no qualifications. Few people think that they “cannot say either one.”

That is, results clarified that certification / specialist nurse positively grasp the “respiratory arrest confirmation” of elderly people. Results presented in this report are similar to results of research examining the discretion expansion of visiting nurses, showing that confidence in knowledge, technology, and judgment affects the responses of more than half of the respondents, who were certified nurses[9]. Having confidence in the ability to confirm respiratory arrest

Table 4　Important points when nurses are responsible for “respiratory arrest confirmation” of elderly people

	category	code
Common Note 1)	1. I commonly recognize and deepen collaboration within the attendance team including family members.	・I try to check with the doctor about possible countermeasures in advance.
		・I consider cooperation with doctors and confirm the death confirmation method considering family background, etc.
		・I maintain good relationships with doctors and remain informed of details in advance.
		・I have confirmed beforehand whether it is possible to visit at the time of respiratory stoppage to multiple doctors in a cooperating visiting clinic.
		・Because I assume that there is preparation for the family's heart to be seen at home, I have shared values of doctors among doctors and nurses.
		・I will explain beforehand what to do after death, negotiation procedures, etc. with the family, doctors and nurses.
		・I confirm the presence or absence of caretaking not once, but every time the state or situation changes. I reconfirm how to contact others at the time of death; how doctors move will be reported to the care staff such as care managers and helpers.
		・When I perform Angel Care, I receive instructions as soon as I confirm three symptoms and report them to the doctor. Alternatively, I talk with the doctor in advance to decide.
		・I am checking the ability to judge the status of understanding and care of the present situation, including who is a family member who can be taken care of, and who will take care of tasks.
		・I confirmed the doctor's instructions and listed them in the nursing record.
	2. I respond while considering the feelings and circumstances of the family	・I am careful to explain to my family about the expected death and gain understanding.
		・I assign great importance to my feelings and thoughts of the family.
		・I get sufficient explanation and consent from the family in advance.
		・I have done enough explanation and have received unequivocal approval from my family.
		・I confirm that there an explanation of the likely state beforehand from the doctor.
		・I have consent of my family, such as acceptance of family members, and they have confirmed light reflection, heartbeat ,etc.
	3. I do Angel Care with respect to users and family feelings	・I have been doing Angel Care since I got consent from doctors and family.
		・I do not basically do stuffing (cotton stuffing) in Angel Care.
		・I do not do felines in the mouth.
	4. I support the user and the family so that they can visit as desired.	・I confirm that the death is confirmed one by one with the family members as well.
		・I tell the progress from the change of the terminal term to the respiratory arrest in advance, conscious of the family subject, and listen to the hope of Angel Care.
		・To cherish the feeling that families have taken care of, when families confirm the time of respiratory arrest, I respect that time to the greatest extent possible.
		・When informing family members of death, I tell the family with few words to avoid becoming mechanical.
Qualification available Note 2)	1. I consider the family's death considering the arrival time of the doctor	・Although I explain that the final judgment is according to the confirmation of the death of the doctor, it is necessary to inform others of it for preparation of the mind and convocation of the family.
		・I wait for the doctor when the family can not accept the death, even if the doctor gives permission to the nurse to confirm the death.
		・I confirm of respiratory arrest and cardiopulmonary arrest, but do not designate it as death until the doctor confirms death.
		・If I get confirmation permission from the doctor in advance, but when I get in touch with the doctor on the day, I contact the doctor in front of the family.
		・I see if the family can accept death and understand. I wait for the doctor's visit if the family says to wait for the doctor
	2. I correctly confirm the signs of death	・I check halting of respiration, cardiac arrest, and pupil dilatation.
		・I observe signs of death correctly.
No qualification Note 3)	1. I wait while supporting the family without doing diagnosis or treatment until the arrival of the doctor	・I am trying to inform family members of death from doctors.
		・I do not take any measures before the doctor arrives.
		・I tell that the death confirmation time is reported to the family when it is confirmed by the doctor (it might be the next morning).
		・I tell the family about disappearance of respiration, cardiac arrest, light reflection, but being informed of the doctor's confirmation will take place at the confirmed time.
		・I will never move or do Angel Care until the doctor has diagnosed the person, even in the event of death.
		・I can not declare death, but because it is obvious that a patient has died, I think that grief care relationships are necessary. I wait while supporting the family as we wait for a doctor.
		・I record death confirmation, but I have a doctor make a judgment of death confirmation at the time of arrival. Angel Care will also be done afterward.
		・I do not declare words because that requires an assumption of death.
	2. I confirm signs of death	・I have confirmed it with my ears.

Note 1): Categories commonly seen by both certified / specialized nurse qualified and unqualified

Note 2): Categories found in persons qualified as accredited / professional nurses Note 3): Categories found in persons qualified as accredited / professional nurses

Note 4): Categories found in persons without qualification of certified / specialized nurse

had some influence on their responses. Furthermore, longer visiting nursing history of certified / specialized nurses who were not qualified led to confidence derived from experience. Regarding precautions to be taken in case of respiratory arrest for elderly people near death, certified specialist nurses report that they can do the following: [I consider the family's death considering the arrival time of the doctor] and [I correctly confirm the signs of death] . However, responses of those who are qualified as accredited / specialized nurses were greatly different in terms of [I confirm signs of death] and [I wait until the arrival pf door while supporting the family without doing diagnosis or treatment]. In other words, accredited and professional nurses strived to assign the family the highest priority to accept death and confirm vital signs correctly, whereas unqualified nurses waited for the doctor' s arrival. The top priority of the law is apparently to prevent action.

Currently, only doctors can create death certificates in Japan (Article 20 of the Medical Practitioners' Act). "Confirmation of death" is an act that can greatly harm the human body if done without the medical judgment and technology that a doctor possesses. It has been said that it must not be permitted to be conducted solely by a nurse. Furthermore, in nursing education, it is taught that patients should not be touched until a doctor arrives [10]. Behind the attention point of nurses who are not qualified as accredited / specialized nurses I think that it was there. However, as a background of attitudes that certified and specialized nurses considered positively about "respiratory arrest confirmation" of elderly people, and that their families had taken top priority on taking death, as a certified / specialized nurse I think that expertise is affecting it, which means that certified nurses and certified nurses specialist have outstanding nursing practical skills, solve problems scientifically, rationally and ethically, and use and adjust the characteristics and professional abilities of related occupations at practical sites. Nurses are educated as role models and as human resources who can act as leaders [11]. The death of elderly people can be characterized as the final settlement of a long life. It must be satisfactory without regret for elderly people and the surviving family. Therefore, it is necessary to support elderly people and their families so that the death of every elderly person can be realized in such a way [12]. In other words, prioritizing legal matters and waiting for confirmation of breathing suspension by doctors who arrive later means that families must accept death and will not be able to support elderly people and their families' desired wishes. Confirming vital signs correctly in such cases is one way to secure care for certified nurses and certified nurse specialists.

2. Characteristics of important points for nurse's respiratory arrest confirmation of death of elderly people at home

Cautionary notes were raised in the case of confirming respiratory arrest by nurses at home: [I respond while considering the feelings and circumstances of the family], [I do Angel Care with respect to patients and family feelings], and [I support the patient and the family so that they can visit as desired] . Those results show that nurses prefer to support elderly people and families' desired wishes, and prefer to support elderly people to make a decision on the long life of elderly people, including their families, to be satisfied with no regrets. Therefore, nurses from judgments comprehensively, including patient viewpoints and their lives in the study of medical practice of visiting nurses[13-15]. Some medical practice can be done according to their own judgment. However, confirming respiratory arrest by nurses at a hospice or palliative care ward, emphasizes routine role-sharing with doctors, relationships of trust with the family, understanding and acceptance of family [7]. At facilities for elderly people, previous reports have described that teams commonly recognize and cooperate and reconfirm vital signs [3]. Based on these facts, the characteristics of being at home are a goal for families seeking rest and dignity for the patient[16].

In addition, visiting nurses must do nursing at the discretion of the nurse to provide better medical care and life support from a patient's perspective, and to carry out care management based on that judgment[17]. Considering this, nurses being responsible for respiratory arrest confirmation for elderly people at

home are providing care management based on the recognition of nurses who respect better care for elderly people and their families and their judgment.

Additionally, the sentiment of [I commonly recognize and deepen collaboration within the attendance team including family members] is in agreement with reported practices [3] at facilities for elderly people. Doctors do not reside at homes and elderly facilities. Therefore, deepening collaboration among team members is an important element for the safe care of elderly people. Characteristics unique to the place of life are indicated. As limitations and difficulties of this research, this study has limitations related to generalization of results because the data were obtained from only a few respondents. Additionally, the possibility exists that thoughts related to respiratory arrest confirmation of visiting nurse are insufficiently reflected in the paper survey questions.

Furthermore, the possibility exists that only persons who felt sufficient confidence responded because the questionnaires were targeted to visiting nurses carrying out respiratory arrest confirmation. Additionally, one must acknowledge that 53 visiting nurses out of 122 people who were not analyzed in this research are “confirmation of respiratory arrest”. In future practice, a visiting nurse doing “confirmation of respiratory arrest” will require that some discussion be made of legal system reform and maintenance of a care system that respects nursing autonomy.

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要　　旨

高齢者の「予想される死」において「呼吸停止確認」を担う場合における注意点について訪問看護師への郵送による質問紙調査を実施した。回答者 122 人のうち、「呼吸停止確認」を「している」群 69 人を分析対象とした。

対象者のうち 28 人が認定・専門看護師の有資格者であり、認定・専門看護師の有資格者は「呼吸停止確認」の実施に「賛成である」と考えている人が有意に多く、「どちらともいえない」と考えている人が有意に少ない現状にあった。「呼吸停止確認」を担う場合における注意点として、【家族を含めた看取りチーム内で共通認識し連携を深める】【家族の気持ちや状況に配慮しながら対応する】【利用者の尊重と家族の気持ちに配慮したエンゼルケアを行う】【利用者および家族が望む看取りができるように支える】が抽出された。さらに、認定・専門看護師の資格を有しない人は【医師の到着までは死亡診断や処置は行わず家族を支援しながら待つ】のに対し、認定・専門看護師の有資格者は【医師の到着時間を考慮した上で家族が死を受け止められるように対応】しており、専門性の特徴が示唆された。

キーワード：看取り　呼吸停止確認　訪問看護師　高齢者　認定・専門看護師